Wakely

BEYOND THE NUMBERS

Commonwealth of Kentucky

Medicaid Rate Development Overview

February 6, 2019

PRESENTED BY

Mary Hegemann, FSA, MAAA

Maria Dominiak, FSA, MAAA

Agenda

- Introduction of Wakely Actuaries
- Rate Development Requirements
- Rate Development Overview
- Jul18 – Mar19 Rate Changes: Region A versus B
- Questions

Introduction of Wakely Actuaries

Wakely is an actuarial consulting firm with over 100 employees, including over 50 credentialed health actuaries. Wakely specializes in health care financing, working directly with government and commercial health insurance carriers on public and private program offerings. Wakely professionals work with public and private boards of directors, advocacy groups, state agencies and authorities, health insurance carriers, hospitals, health centers, and physician groups.

The Wakely Team has prepared Medicaid actuarial certifications in over 20 states.

Our team members also serve as reviewers of Medicaid managed care certifications for CMS.

Introduction of Wakely Actuaries

Mary Hegemann is a Fellow of the Society of Actuaries, Member of the American Academy of Actuaries, and has 22 years of actuarial experience in the health care field. Eighteen of those years have been spent consulting a variety of Medicaid clients including states, plan associations, and two non-profit Medicaid managed care organizations. Mary has provided Medicaid and 1115 waiver certifications to CMS for the most recent seven years. Mary has worked with states and participating MCOs to determine risk adjustment methodologies and has implemented risk adjustment, specifically CDPS+Rx and other tools, in state Medicaid programs. In addition to Kentucky, Mary's Medicaid work and actuarial services for 1115 waiver populations have been concentrated in Oregon, Colorado, West Virginia, Michigan, Arizona, Missouri, and Texas.

Introduction of Wakely Actuaries

Maria Dominiak is a Fellow of the Society of Actuaries, Member of the American Academy of Actuaries, and has over 25 years of actuarial experience in the health care field consulting to over 20 states and the federal government on policy, program design, data collection and analysis, financial analysis and rate setting, waivers, procurement, implementation and ongoing operational issues related program monitoring, both in Medicaid managed care and fee-for-service delivery systems. Maria is a nationally recognized expert on actuarial and financial issues related to Medicaid. Maria has also been the certifying actuary for Medicaid managed care rates in over ten states including Connecticut, District of Columbia, Georgia, Kansas, Kentucky, Maryland, Massachusetts, New Mexico, New York, North Carolina, and Tennessee. Maria also served as an actuarial reviewer for CMS Office of the Actuary (OACT) on Medicaid managed care rate certifications and provides technical assistance to states through the CMS Medicaid Innovation Accelerator Program on value-based purchasing and financial models.

Introduction of Wakely Actuaries

Additional Wakely Team Actuaries Supporting Kentucky Medicaid Rate Setting

- Ernest Jaramillo, ASA, MAAA – has over 15 years of experience as a consulting and health plan actuary, specializing in fiscal and policy analysis for fee-for-service and Medicaid managed care programs.
- Tom Garrity, ASA, MAAA – has over 16 years of industry experience working with a broad range of health insurance products. Tom is involved with detailed evaluation and validation of Medicaid data sources as well as tool development including claims trend, repricing, IBNR, program adjustments, and projections.
- Suzanna-Grace Sayre, FSA, CERA, MAAA – has over 12 years of actuarial experience, including consulting with state Medicaid departments and working as a public programs actuary at an individual managed care organization. She also has extensive risk-adjustment experience in multiple lines of business including Medicaid, Medicare, and the ACA.

Rate Development Requirements

Rate Development Requirements

Definitions

- Capitation rates: The amount paid to Medicaid Managed Care Organizations (MCOs) to be at financial risk for health care services for the covered population. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. Capitation rates are funded with a combination of State and federal funds.
- Per member per month (PMPM): A statistic used in health care. For example, a $400 PMPM capitation rate would refer to a monthly payment of $400 for each member covered by a Medicaid MCO.

Rate Development Requirements

42 CFR §438.4 Actuarial Soundness

- 1903(m) of the Social Security Act requires that capitation rates paid to managed care organizations be actuarially sound in order for a State to receive FFP on the capitation payment.
- 42 CFR §438.4(a) ***Actuarially sound capitation rates defined.*** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

Rate Development Overview

42 CFR §438.4 Actuarial Soundness

(b)*CMS review and approval of actuarially sound capitation rates.* Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

(1) Have been developed in accordance with standards specified in §438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.

(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.

(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.

(4) Be specific to payments for each rate cell under the contract.

(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.

Rate Development Requirements

42 CFR §438.4 Actuarial Soundness

(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in §438.3(c)(1)(ii) and (e):

- 438.3(c)(1)(ii): State plan services and additional services for compliance with mental health parity standards
- 438.3(e): Does not include value-added services and includes in lieu of services if such services are authorized under the contract

(7) Meet any applicable special contract provisions as specified in §438.6.

(8) Be provided to CMS in a format and within a timeframe that meets requirements in §438.7.

(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

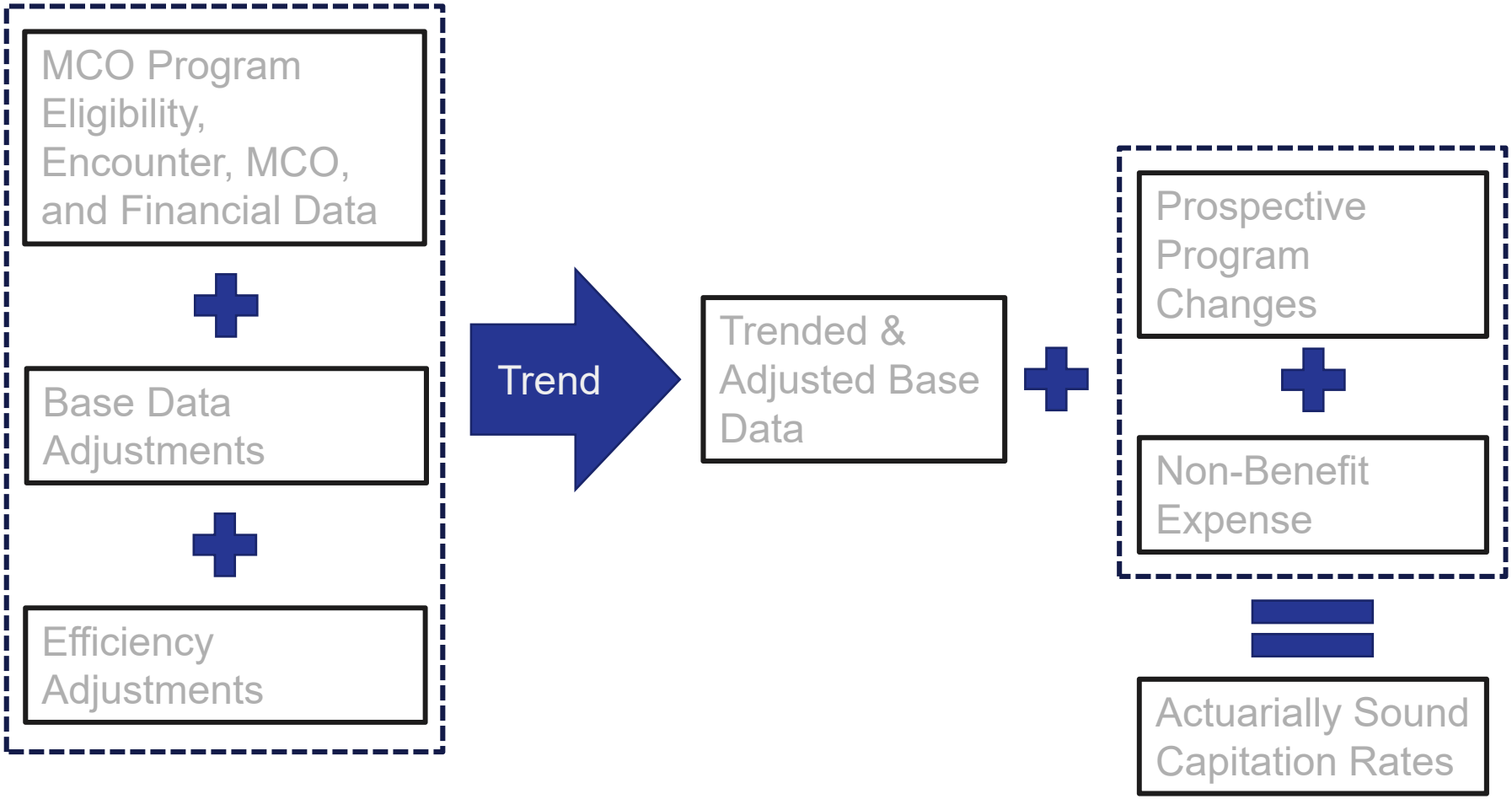
Rate Development Requirements

- Rates developed in accordance with federal and state rules and regulations
- Rates developed in accordance with actuarial standards of practice (ASOP), including the following:
  - ASOP No. 1, Introductory Actuarial Standard of Practice
  - ASOP No. 5, Incurred Health and Disability Claims
  - ASOP No. 23, Data Quality
  - ASOP No. 25, Credibility Procedures
  - ASOP No. 41, Actuarial Communications
  - ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies
  - ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification
- Capitation rates are developed to include reasonable, appropriate, and attainable costs on a regional and rate cell basis and are not MCO specific

Rate Development Overview

Rate Development Overview

Summary of Rate Development Process



Rate Development Overview

Summary of Rate Development Process

Development of an Actuarially Sound Rate Range

- Construct base data using detailed encounter data and other financial information
- Adjust base data to reflect changes in program design from the base to contract period
- Apply claim cost trend adjustments to reflect changes in utilization, unit cost, and service mix intensity
- Prospective program changes
- Add non-benefit expense load (care management, claims processing, other administrative costs) including profit margin and premium assessment

Subsequent Steps

- Selecting rates within rate range
- Risk adjustment
- Actuarial certification of final rates
- CMS review and approval

Rate Development Overview

Selection of Rates within the Rate Range

- Assumptions provide for a range of estimates
  - Jul18-Mar19 rate range is approximately 3%, meaning the highest certifiable rates are 3% greater than the lowest certifiable rates
- DMS selects a percentile within the range
  - SFY18 rates: 15th percentile
  - Original Jul18-Dec18 rates: 15th percentile
  - Final Jul18-Mar18 rates:
    - DMS decision to extend Jul18-Dec18 rates three more months
    - Actuarially sound rate range was updated to 9-month rate period
    - Result is that rates are paid near the low end of the rate range, but are still within the actuarially sound rate range. Percentile differs by rate cell.
- DMS selects the same percentile for all MCOs

Rate Development Overview

Risk Adjustment

- MCOs who enroll members with greater health problems get paid more through risk adjustment. MCOs who enroll members with fewer health problems get paid less.
  - 438.5(a): Risk adjustment is a methodology to account for the health status of enrollees via relative risk factors
- Risk adjustment is budget neutral to the state and CMS (438.5(g))
  - Rate group and Region (e.g., TANF children in Region A)
- Risk adjustment factor is applied to the selected base rate
- Diagnosis codes in claim encounters drive results
- Uses CDPS+Rx, a nationally recognized tool for Medicaid

Jul18 - Mar19 Rate Changes
Region A versus Region B

Actuarially Sound Rate Structure

Guiding Principles

- Maintain Homogeneity
- Minimize Adverse Selection
- Increase Credibility
- Assess Practicality

Region A versus B

- As of July 1, 2018, rates were consolidated to two rating regions (from 8)
  - Rating Region A: Region 3
  - Rating Region B: Regions 1,2,4,5,6,7, and 8

Region A versus B

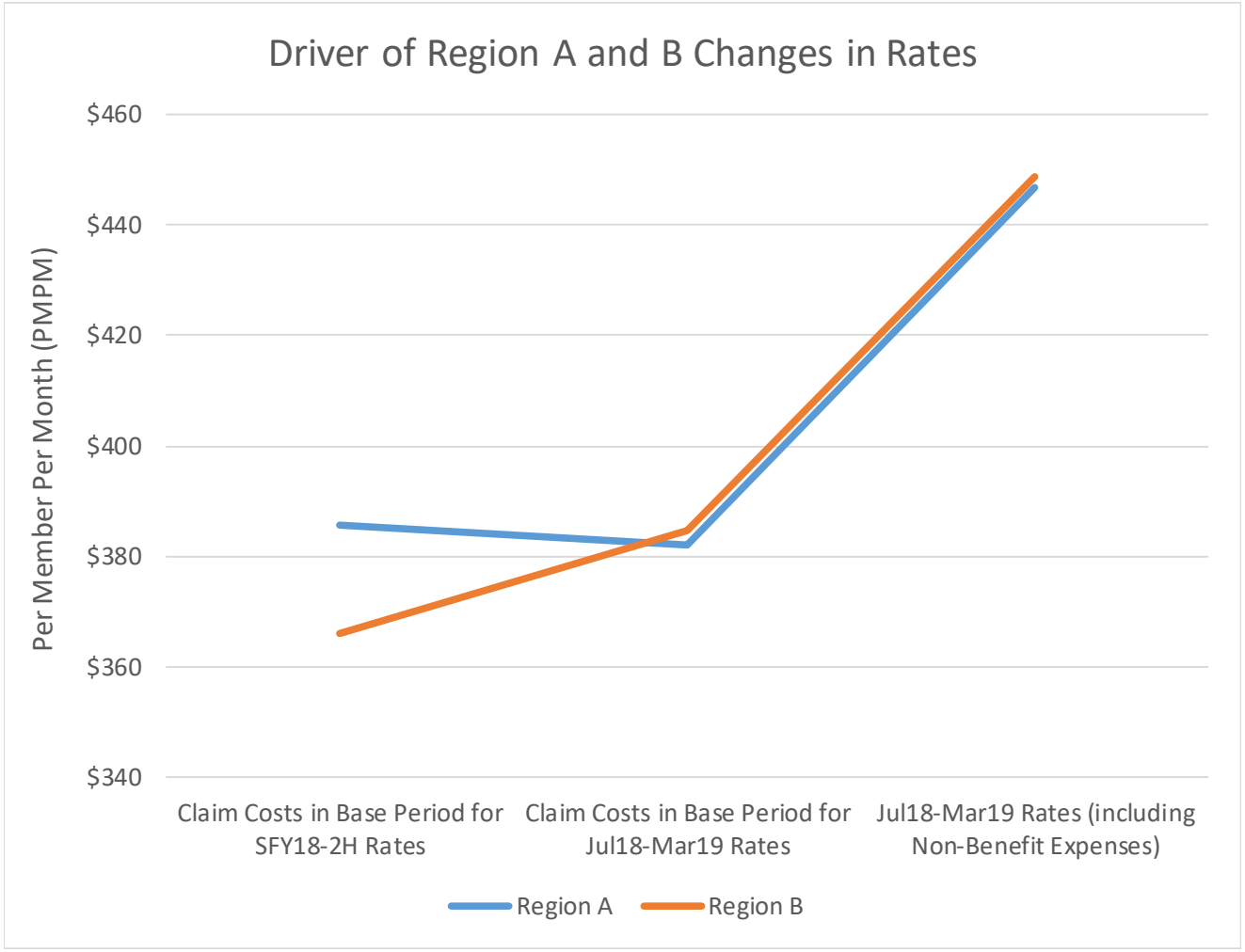
Rate Changes from SFY18-2H (Jan18-Jun18) to Jul18-Mar19

Key drivers of changes:

- Updated base period data (re-basing)
- Trends
- Program changes
- Updated administrative costs

Region	Re-basing	Other Changes	Total
A	-1%	-3%	-4%
B	5%	-3%	2%
Statewide	4%	-3%	1%

Region A versus B



Source: Actuarial rate certifications for the respective rate periods

Questions

Disclosures and Limitations

Responsible Actuary. Mary Hegemann and Maria Dominiak are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. The information contained in this report, including the exhibits, has been prepared for the Kentucky Department for Medicaid Services (DMS) and their advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Risks and Uncertainties. The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that the Commonwealth MCOs will attain the results included in the report. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Kentucky.

Disclosures and Limitations

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. Material changes by the Commonwealth or in state or federal laws or regulations regarding Medicaid plans may have a material impact on the results included in this report. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document, including the ratebook and rate certification pertaining to MCO rates effective July 2018 through March 2019 (including their supporting exhibits/files), constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations.